



# Kuraneza: A “Good Growth” Project in Rwanda

## PROJECT DATES

October 2010 – September 2014

## PROJECT BUDGET

USAID contribution: \$1,750,000

CARE International contribution: \$650,358

## LOCATION

Kamonyi District, Southern Province, Rwanda

## CONTEXT

Rwanda has made impressive gains in maternal, infant, and child health — between 2005 and 2010 under-5 mortality dropped from 133 deaths per 1,000 live births to 76, and chronic malnutrition dropped from 51 to 44 percent — but there is considerable room for improvement. A major challenge is the heavy workload of the country’s 60,000 community health workers. In rural Kamonyi District, relatively high rates of poverty and low primary care indicators are combined with a dearth of organizations working on maternal and child health. In line with the government’s emphasis on community-based service delivery, *Kuraneza* worked to mobilize communities to improve child survival and early childhood development in the district. (Data source: [Rwanda Demographic and Health Survey, 2010](#))



*KamonyiDist* by I, SteveRwanda (via Wikimedia Commons)

## BENEFICIARY POPULATION

Total population in the project area: 88,307

20,047 women of reproductive age (15–49 years)

11,149 children under 5 (0–59 months)

## PROJECT AT A GLANCE

	Maternal	Newborn	Child
Household	✓	✓	✓
Community	✓	✓	✓
Facility			
District			
National			

## Project Approach

Rwandan government policies emphasize community-based service delivery for maternal and child health, nutrition, and early childhood development (ECD), but the heavy workload of the country’s community health workers (CHWs) is a major challenge to service delivery. The *Kuraneza* (“Good Growth”) Child Survival project tested a model to integrate child survival and ECD as a means of giving CHWs greater access to groups of women, men, and children and assistance from home-based ECD mother leaders created by the project. The goal was to contribute to reductions in maternal and child mortality in rural Rwanda, while improving equity.

*Kuraneza* worked in four sectors (sub-districts) of Kamonyi, a rural district in central Rwanda. In one sector (the “comparison” zone), the project trained CHWs to work directly with mothers and households, in line with government strategy. In three other sectors (the “intervention” group), the project augmented the government strategy by embedding it in an ECD program. The program included home visits with pregnant women and mothers of infants up to 12 months, home-based groups of mothers with children 1 to 3 years old, and ECD centers for children 3 to 6 years old.

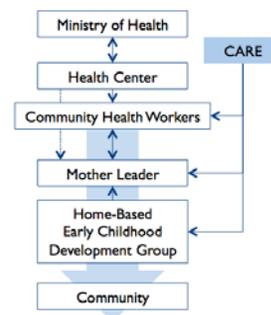
DESIRED OUTCOME	MAIN ACTIVITIES AND SELECTED OUTPUTS
Improve maternal and newborn care	<ul style="list-style-type: none"> <li>✓ 12 CHW supervisors trained in supportive supervision</li> <li>✓ 312 CHWs trained once on maternal and newborn care, behavior change communication, adult learning, maternal and child death audits, and RapidSMS*</li> </ul>
Improve community management of childhood illnesses	<ul style="list-style-type: none"> <li>✓ 208 CHW teams (each with 1 male and 1 female) trained twice on community-based integrated management of childhood illness</li> <li>✓ 4 community sensitization meetings per sector on good maternal health practices, diarrhea and acute respiratory infection management, and use of bednets</li> </ul>
Improve infant and young child feeding and child nutritional outcomes	<ul style="list-style-type: none"> <li>✓ 6 CHW learning sessions on exclusive breastfeeding</li> <li>✓ 104 CHWs trained to facilitate mother leader group training on infant and young child feeding</li> </ul>
Improve cognitive, emotional, and psychosocial development in targeted children	<ul style="list-style-type: none"> <li>✓ 6 ECD centers built/rehabilitated and equipped</li> <li>✓ 330 mother leaders trained in 3 sectors</li> <li>✓ Health and nutrition integrated into ECD activities</li> </ul>

\* *RapidSMS* is a mobile (text messaging) platform for faster data collection and workflow coordination.

## Partnerships

*Kuraneza* integrated child survival interventions with home-based ECD groups (created and initially run by CARE, then by local authorities), in which groups of 8 to 10 self-selecting mothers and pregnant women took turns providing care while the others worked. A CHW trained the group, and each group elected a volunteer mother leader to coordinate activities with the local health facility and the CHW. The CHWs provided regular training on health and nutrition for mother leaders, who then trained other women and men in their communities.

Mother leaders also conducted community outreach to help identify pregnant women and those who were not otherwise accessing services.



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## A Feasible Approach for Child Survival

The *Kuraneza* project evaluation indicates that integrating child survival and ECD programming was a feasible approach that contributed to nutrition and child survival and yielded efficiencies for CHW workload. More study may be needed about whether the integrated approach has significantly more impact than the government’s standard approach of simply training and supporting CHWs. Moreover, poverty and food insecurity are key challenges to child survival that may require integrated anti-poverty and food security activities to address nutrition, particularly for vulnerable households.

## Key Findings

The project evaluation used data from knowledge, practice, and coverage surveys carried out with mothers of children under 2 years in the comparison sector and one intervention sector at baseline (2011; n=858) and endline (2014; n=845), as well as in-depth interviews, site visits, and reviews of project and policy documents.

- **Nutrition and Child Survival.** Overall, the project area saw significant improvement in nutrition, maternal health practices, and use of bednets (Figures 1 and 2). However, evaluation findings indicate that socioeconomic status was a factor in many child survival outcomes, and food insecurity limited many families’ ability to contribute to meals provided through the ECD programs. There were frequent qualitative references to poverty as a key challenge.
- **Community Engagement.** Mother leaders were able to fulfill many of the roles tasked to them, and were respected CHW partners. The reported level of engagement by fathers also increased across the comparison and intervention sectors.
- **CHW Workload.** Intervention-zone CHWs reported that the integrated approach yielded efficiencies that reduced their workload, although there were no

better results in coverage in the intervention zone compared with the Child Survival-only zone.

- **Effect on ECD.** There were no distinguishable, consistent differences in ECD for those in the ECD program. ECD was measured using the [Ages and Stages Questionnaire](#), which had not been used in Rwanda, although there was an intensive process to translate the tools into the local language. Lack of distinguishable differences in ECD may be due to ineffective programming or unsuitability of the tools for Rwanda, where large proportions of children fell below U.S. cutoffs for developmental lags.

## Lessons Learned

- **Poverty and Food Security.** Include mechanisms to penetrate the poverty barrier, including adaptive and participatory approaches to benefit the poorest households and deeper incorporation of behavior change theory, along with social service programming. Integrating anti-poverty and food security activities, especially those targeting vulnerable households, may help mitigate poor nutrition outcomes.
- **Training Approaches.** CHWs and mother leaders requested more frequent training, and there was a dearth of data on the efficacy of the capacity development program. It could be useful to institute pre/post knowledge and competency assessments of mother leaders and CHWs. More frequent training modules may be preferable to *Kuraneza*’s model.

## Contact for More Information

CARE International  
151 Ellis Street, NE, Atlanta, Georgia 30303  
404-681-2552 | [kroy@care.org](mailto:kroy@care.org) | [care.org/country/rwanda](http://care.org/country/rwanda)

Figure 1. Maternal Health Results

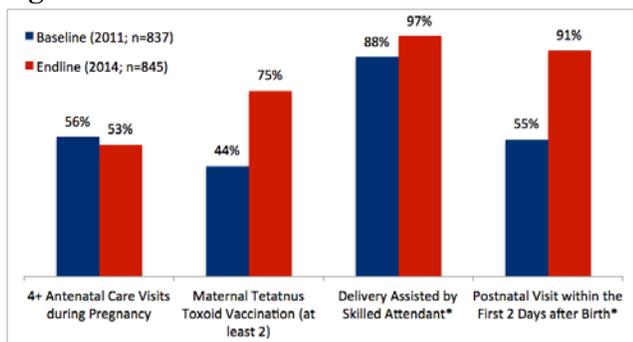
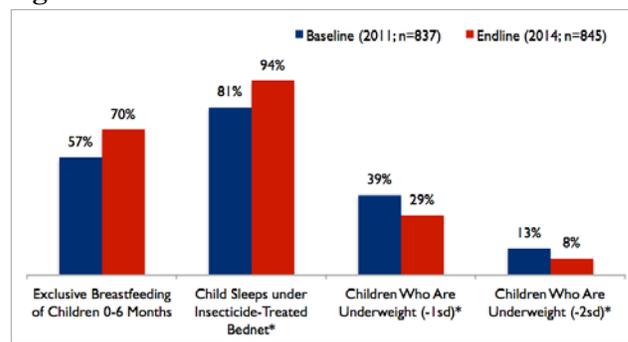


Figure 2. Infant and Child Health Results



\* indicates statistical significance at  $p < 0.05$

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